Sun Life Assurance Company of Canada

Long Term Disability Claim Packet

Sun Life Financial℠

Instructions for the Plan Administrator

Please make sure that the employee initiates the Long Term Disability claim filing process as soon as it first appears that his or her disability will extend beyond the required elimination period. Please refer to your group insurance policy to determine the length of the elimination period.

The LTD claim packet requests information that is critical to the timely and accurate administration of the claim. This information is used to determine benefits according to the group insurance policy under which the employee is covered.

There are five sections to be completed in this packet:

A Employer's Statement

B Employee's Statement

C Authorization

D Reimbursement Agreement

E Attending Physician's Statement

The employee is responsible for completing Sections **B**, **C** and **D** of this packet as well as collecting Section **A**, completed by the employer, and Section **E**, completed by the attending physician. The employee also is responsible for collecting additional supporting documentation that may be required for the claim. The employee must forward all completed sections and supporting material to Sun Life Assurance Company of Canada before we can begin processing the claim. If the claim form is not completed in full, processing of benefits will be delayed until all of the required information is received.

Please call our Customer Service Center at 1-800-247-6875 to report any scheduled or actual return-to-work dates as soon as possible.

If the employee is submitting a Waiver of Premium claim, also include copies of all of his/her Basic and/or Optional enrollment forms and the recent payroll record prior to the loss.

Special Instructions for the Employee

Before you send us your completed claim forms, please review this checklist to make sure that you have included all of the information listed.

Employee Checklist

If you do not provide the fully completed claim packet and all additional supporting documentation, your benefits could be delayed until all of the required information is received.

Did you...

☐ Complete and sign the "Employee's Statement" (Section **B** of this packet) answering all questions in as much detail as possible (especially your full address and phone number)?

☐ Sign and date the "Authorization" (Section **C**)? This will allow Sun Life Assurance Company of Canada to obtain additional information, if necessary, to make a decision on your claim. All information related to your claim is kept strictly confidential.

☐ Complete, sign and date the "Reimbursement Agreement" (Section **D**)? This form outlines an agreement concerning coordination of benefits. Please disregard completion of this agreement if your employer is located in Pennsylvania.

☐ Arrange for your employer to complete the "Employer's Statement" (Section **A** of this packet)?

☐ Arrange for your doctor to complete the "Attending Physician's Statement" (Section **E**)? Incomplete medical information could lead to delays in the resolution of your claim. If there is more than one treating physician, please send a separate form to each provider.

☐ Enclose all treatment notes and results from diagnostic tests (i.e. x-rays, lab work, etc.) from all physicians from whom you have received care since your last day of work?

continued on next page

Special Instructions for the Employee (continued)

☐ Verify that your employer will send us a job description and any additional information required by the policy (i.e. enrollment form, prior year's W-2, payroll records, etc.)?

☐ If you are submitting this claim packet for Waiver of Premium in addition to LTD, please verify that your employer has supplied the Basic and/or Optional enrollment form, payroll record and other required documentation in your Waiver of Premium/LTD submission.

Mailing Instructions

After you have collected all of the forms, medical records and other documentation listed above, make a copy for your records and mail to the address below. To avoid delay in processing your claim, please mail all documents three to four weeks before the end of your elimination period.

Sun Life Assurance Company of Canada
Group Long Term Disability Claims, SC 3208
One Sun Life Executive Park
P.O. Box 81830
Wellesley Hills, MA 02481

PLEASE NOTE: After Sun Life Assurance Company of Canada receives your claim, we may need to request additional information to determine your eligibility for benefits.

We will contact you as soon as we have received and reviewed your claim forms and medical records. In the meantime, should you have any questions, please call our Customer Service Center at 1-800-247-6875.

Fraud Warnings

State law requires that we notify you of the following:

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Warning - For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning - For Residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning - For Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning - For Residents of Louisiana and Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning - For Residents of Maryland: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime as determined by a court of competent jurisdiction.

Fraud Warning - For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Fraud Warning - For Residents of Oregon, Virginia and Washington: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Sun Life Assurance Company of Canada
Long Term Disability Claim
Section A: Employer's Statement

Sun Life Financial℠

1. Information About the Employer

Please PRINT clearly.

Return to:
Sun Life Assurance
Company of Canada
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Employer's Name	Group Policy Number	Subdivision	Class
Employer Contact (name of person completing this form)	Title		
Employer's Street Address	City	State	Zip Code
Employer's Email Address	Telephone Number	Fax Number	
Name and Address of Division Where Employee Works (if different from above)			

Does your company have a formal Return to Work Program? . . . . . ☐ Yes ☐ No

If so, please provide the following information:

Contact Person	Telephone Number

2. Information About the Employee

Employee's Name (first, middle initial, last) ☐ Male ☐ Female	Social Security Number	Date of Birth (m/d/y)
Employee's Street Address	City	State	Zip Code

3. Information About Employment and the Claim

A. Date Employee Hired (m/d/y)	B. Date Employee Effective Under this Policy (m/d/y)
C. Date Employee Last Worked (m/d/y)	D. Number of Hours Worked – Last Day

E. What was the employee's permanent occupation on his/her last date of work?

F. How long had employee been in this occupation?

G. Why did the employee cease working?

H. Was insurance in force when disability began? ☐ Yes ☐ No	If no, give termination date (m/d/y)

I. What was the employee's regularly scheduled work week?
Days Per Week Hours Per Day

J. Is the condition due to an injury or sickness arising out of the employee's job?
☐ Yes ☐ No ☐ Disputed

K. Has a Workers' Compensation claim been filed?
☐ Yes ☐ No If yes, please send initial report of illness/injury and award/denial notice.

L. Name and Address of Your Workers' Compensation Carrier

M. Was employee covered under prior LTD policy?
☐ Yes ☐ No

Effective Date Under Prior Policy (m/d/y)	Termination Date Under Prior Policy (m/d/y)

N. Has employee returned to work? ☐ Yes ☐ No If yes, ☐ With Restrictions ☐ Full Capacity	Date Returned (m/d/y)

4. Information About the Employee's Salary

A. How was the employee paid? (check one)

☐ Hourly ☐ Salaried

Rate per Hour	Salary per Week
$	$

B. Please provide information about other income:

☐ Commissions ☐ Bonuses ☐ Overtime

$	$	$

5. Information About Other Sources of Income

To the best of your knowledge, is the employee receiving, or entitled to receive, benefits from any of the following sources during the employee's disability?

Source of Income	Amount/ (Week/Month)	Date Payments Began	Date Payments End
Sick Pay			
Salary Continuance			
State Disability			
Workers' Compensation			
Unemployment Compensation			
Social Security Disability/Retirement			
Disability/Retirement Pension			
Automobile No-fault Insurance			
Union Disability			
Other Group Disability Benefits			

6. Information Needed for Withholding and Reporting Taxes

A. Does employee contribute toward the LTD premium? ☐ Yes ☐ No	Percentage paid by Employee % Employer %
B. Are employee's premium contributions made with pre-tax dollars? ☐ Yes ☐ No	

7. Information About the Employee's Occupation

Please give detailed description of job duties including the physical demands and submit employee's formal job description.

Employee's Job Title

8. Information About the Physical Aspects of the Occupation

A. In a typical work day, give the number of hours the employee spends in each of these positions and if employee may alternate positions.

Position	Total Number of Hours	May Alternate Positions: At Will	15-30 Minutes	Hourly	Never
Sitting					
Standing					
Walking					
Driving					

B. In a typical work day, the employee must:

	Occasionally (¼ - 2 ½ hours)	Frequently (2 ½ - 5 ½ Hours)	Continuously (5 ½ - 8 hours)	Never
Bend/Stoop				
Climb				
Reach Above Shoulder Level				
Kneel				
Balance				
Push/Pull				
Crawl/Crouch				
Lift _____lbs				
Carry _____lbs				

C. Does the employee use feet for repetitive movements, as in operating foot controls?
Right foot ☐ Yes ☐ No Left foot ☐ Yes ☐ No Both feet ☐ Yes ☐ No

D. What are the major tasks requiring use of one or both hands?

	One Hand	Both Hands

E. Which of the following describes the employee's working environment?

Check all that apply.

☐ Working at heights
☐ Operating heavy machinery
☐ Changes in temperature or humidity
☐ Exposure to dust, fumes and gases
☐ Precise manual dexterity
☐ Other hazards (specify)

9. Stress/Non-Physical Aspects of the Job

A. Does employee have to answer customer complaints? ☐ Yes ☐ No

B. Is employee primarily evaluated on production? ☐ Yes ☐ No

C. Is employee routinely subject to close supervision? ☐ Yes ☐ No

D. Does employee work closely with his/her co-workers? ☐ Yes ☐ No

E. Is employee responsible for the overall performance of his/her particular department? ☐ Yes ☐ No

F. Number of people this employee supervises

10.Required Attachments for Person Completing this Section of the Form

A. If the employee contributes to the premium, attach a copy of the enrollment form.

B. If you have medical information from the employee's file relating to this disability, please attach copies.

C. Attach a copy of the employee's formal job description, if available.

11.Signature

Name of Person Completing this Section	
Title of Person	
Telephone Number	Fax Number
Signature X	Date (m/d/y)

The above statements are true and complete to the best of my knowledge and belief.

Sun Life Assurance Company of Canada
Long Term Disability Claim
Section B: Employee's Statement

Sun Life Financial℠

1. Information About You and Your Family

Please PRINT clearly.

This information is required to determine your eligibility for Social Security benefits.

Return to:
Sun Life Assurance Company of Canada
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

Your Name (first, middle initial, last)			Policy Number
Your Street Address	City	State	Zip Code
Social Security Number	Date of Birth (m/d/y)	☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Your Occupation		Telephone Number	
Your Spouse's Name (first, middle initial, last)	Social Security Number	Date of Birth (m/d/y)	

Is your spouse employed? . . . . . ☐ Yes ☐ No

Names and Dates of Birth of Your Children (under age 25)

2. Information About the Condition Causing Your Disability

A. Date of Accident or Date You First Noticed Symptoms of Your Illness	
B. Describe in detail how, when and where the accident occurred or describe the nature of your illness and its first symptoms	
C. Date You Were First Treated by a Physician	
D. Name, Address and Phone Number of First Treating Physician	
E. Is your condition due to injury or sickness related to your job? . . . . . ☐ Yes ☐ No If yes, please explain below.	
F. Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If yes, provide date.	Date (m/d/y)

3. Information About the Disability

A. Last Day You Worked Prior to the Disability	B. Did you work a full day? ☐ Yes ☐ No
C. Date You Were First Unable to Work (m/d/y)	
D. Have you returned to work? ☐ Yes ☐ No If yes, ☐ With Restrictions ☐ Full Capacity	Date Returned (m/d/y)

4. Information About Physicians and Hospitals

If you need more space, attach additional pages.

A. Please provide the names and addresses of all physicians you have seen for this condition.

Name	Telephone Number
Address	
Specialty	Date of Treatment (m/d/y)

Name	Telephone Number
Address	
Specialty	Date of Treatment (m/d/y)

B. If you have been hospital-confined for this condition, please provide names and addresses of hospitals and confinement dates.

Name of Hospital(s)	Address	Dates of Confinement

5. Information About Other Income

Provide award/denial notice or application associated with any source of income referred to in this section.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

Source of Income	Amount/ (Week/Month)	Date Payments Began	Date Payments End
Sick Pay			
Salary Continuance			
State Disability			
Workers' Compensation			
Unemployment Compensation			
Social Security Disability/Retirement			
Disability/Retirement Pension			
Automobile No-fault Insurance			
Union Disability			
Other Group Disability Benefits			

6. Information About Your Training, Education and Experience

A. Have you received a high school diploma or the equivalent of a high school diploma?
☐ Yes ☐ No If no, what is the last grade you completed?

B. Have you attended college? ☐ Yes ☐ No
If yes, specify ☐ Some College ☐ College Graduate ☐ Post Graduate

Major Field of Study	Degree Earned	Date Last Attended

C. Have you attended any trade schools or received any other special training? ☐ Yes ☐ No

Type of Training	Date Last Attended

D. What was your occupation when the disability began and what were the usual duties of your occupation?

E. Which of the above duties are you unable to perform?

F. Have you discussed returning to work or starting a vocational rehabilitation program with your doctor? ☐ Yes ☐ No

G. Have you asked your employer to provide any accommodations which would allow you to return to work? ☐ Yes ☐ No

If yes, what accommodations did you request and what was your employer's response?

H. What accommodations do you feel could be made by your employer to allow you to return to work?

I. Have you considered retraining? ☐ Yes ☐ No If yes, what vocational area(s) would interest you?

Please attach resume, if available.

J. Please list all previous employers and the dates worked for each employer

Employer's Name	**Dates of Employment**	**Type of Work**

K. Please list any hobbies, outside interests or activities

L. Briefly describe your daily routine, including all the tasks you currently perform

M. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding rehabilitation? ☐ Yes ☐ No
If yes, what is the name, address and telephone number of the counselor handling your case?

Name	Address	Telephone Number

N. Have you contacted your state Vocational Rehabilitation Department? ☐ Yes ☐ No
If yes, what is the name, address and telephone number of the counselor handling your case?

Name	Address	Telephone Number

O. Would you like our Vocational Rehabilitation department to contact you to discuss options available which may assist you in returning to gainful employment? ☐ Yes ☐ No

7. Authorization

I certify that the above statements are true and complete and I authorize physicians, hospitals and my employer to release information with respect to this claim. I understand that some states require Sun Life Assurance Company of Canada to notify me that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employee's Signature X	Date (m/d/y)

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Sun Life Assurance Company of Canada
Long Term Disability Claim
Section C: Authorization

Sun Life Financial℠

1. Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

Return to:
Sun Life Assurance Company of Canada
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; or the Medical Information Bureau, Inc., to disclose my entire medical record and any other protected health information concerning me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affiliates, third party administrators and reinsurers.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases and mental illness, and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any entity named above to release and disclose my entire medical record without restriction.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize The Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining and/or adjudicating my claim. I further authorize The Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

I understand that The Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

2. Authorization for Release and Disclosure of Psychotherapy Notes

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, therapist or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) insurance company; and (c) insurance support organization to disclose any psychotherapy notes relating to me to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affiliates, third party administrators and reinsurers.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any entity named above to release and disclose all psychotherapy notes relating to me without restriction.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize The Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim.

I understand that The Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

3. Authorization for Release and Disclosure of Non-Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read and sign all three Authorizations. Failure to sign all three Authorizations could result in a delay during the claims process.

I HEREBY AUTHORIZE any: (a) physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy or other medical or health care facility that has provided payment, treatment or services to me or on my behalf; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., Social Security Administration, Internal Revenue Service or the Veteran's Administration, to disclose to Sun Life Assurance Company of Canada ("The Company") its subsidiaries, affiliates, third party administrators, and reinsurers, any and all non-health information relating to me, including, but not limited to, (a) my employment earnings; (b) my occupational duties; (c) my credit history, (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I, or my dependents, may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

If this Authorization is signed in connection with a claim for insurance benefits, I hereby authorize The Company to disclose any information it obtains about me to any: (a) insurance company; (b) third party administrator; (c) rehabilitation or vocational professional; and (d) treating physician, psychologist or therapist/counselor of mine, for the purpose of verifying, evaluating, negotiating, determining, and/or adjudicating my claim. I further authorize The Company to disclose any information it obtains about me to the Medical Information Bureau, Inc.

I understand that The Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to the Group Compliance Department, Sun Life Financial, SC 2260, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Authorized Representative	Group Policy Number
Signature of Employee or Authorized Representative X	Date (m/d/y)

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Sun Life Assurance Company of Canada
Long Term Disability Claim
Section D: Reimbursement Agreement

Sun Life Financial℠

Return to:
Sun Life Assurance
Company of Canada
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

I UNDERSTAND that the provisions of the Group Long Term Disability Policy No._____ permit Sun Life Assurance Company of Canada (herein called the Company) to subtract from my monthly disability benefit any benefits received from Social Security and/or Workers' Compensation or as otherwise provided in the Group Long Term Disability Policy. I further **UNDERSTAND** that the Company is also entitled to consider such benefits as being received where claim therefore is pending or when it is reasonable to believe that I or my dependents are eligible for them.

In return for the Company's advance payment of the Long Term Disability benefits to which I am entitled, which may be in excess of the amount due to me under the terms of the policy, I, for myself, my heirs, executors, administrators and assigns agree:

1. That I am not currently receiving any benefits from Social Security and/or Workers' Compensation.
2. To apply for Social Security disability benefits and/or Workers' Compensation benefits payable for this disability.
3. If I, and/or my spouse and family receive any disability payments, regardless of the amount, in connection with Social Security and/or Workers' Compensation, I and/or my spouse and family will immediately notify the Company of such disability payments and will pay back all amounts of such advances over and above the amounts to which I would be entitled under the policy provisions.
4. I understand that thereafter the Company is entitled to integrate any amounts received from Social Security and/or Workers' Compensation with the monthly benefit payable under the policy in accordance with the terms of the policy.

I UNDERSTAND that the Company, in reliance on the above statements and promises, has agreed to advance to me the disability benefits to which I am entitled under the terms of the policy.

Print Name	Group Policy Number
Signature of Employee X	Date (m/d/y)
Signature of Witness X	Date (m/d/y)

Sun Life Assurance Company of Canada

Long Term Disability Claim
Section E: Attending Physician's Statement

Sun Life Financial℠

1. Information About the Patient

To be completed by the Physician and returned to Sun Life Assurance Company of Canada.

Please PRINT clearly.

Return to:
Sun Life Assurance Company of Canada
Group LTD Claims,
SC 3208
1 Sun Life Exec. Park
P.O. Box 81830
Wellesley Hills, MA 02481
Fax: (781) 304-5537

The patient is responsible for any costs associated with the completion of this form.

Name of Patient (first, middle initial, last)	Social Security Number	Date of Birth (m/d/y)	
Street Address	City	State	Zip Code
Employer Name		Group Policy Number	

2. History

A. When did symptoms first appear or accident happen?	B. Date Disability Commenced
C. Has patient ever had same or similar condition? ☐ Yes ☐ No If Yes, when?	
D. Is condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No ☐ Unknown	
E. If condition is due to automobile accident, indicate state in which accident occurred	
F. Names and Addresses of Other Treating Physicians (if applicable)	
G. Patient's Height	Patient's Weight

3. Diagnosis

* Include current X-Rays, EKGs, MRIs, laboratory data and any other clinical findings.

A. Diagnosis Including Any Complications and ICD9 Code(s)	
B. Objective Findings*	
C. Subjective Symptoms	
D. If pregnancy, what is expected date of delivery?	E. If pregnancy, what was actual date of delivery?
F. Please describe any complications that would extend this disability longer than a normal pregnancy	

4. Treatment for this Condition

Include surgery, therapeutic modalities, psychological intervention and medications prescribed, if any.

A. Date of First Visit	B. Date of Last Visit	C. Date of Last Examination
D. Frequency of Treatment ☐ Weekly ☐ Monthly ☐ Other If other, please specify		
E. Nature of Treatment		

5. Progress

A. Has Patient ☐ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed	B. Is Patient ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined	
C. If unchanged or retrogressed, please explain		
D. Has patient been hospital confined? ☐ Yes ☐ No	From	Through
E. If yes, give name and address of hospital		

6. Limitations

A. In a normal day, the patient may:

1. Stand/Walk	☐ None	☐ 1 - 4 hours	☐ 4 - 6 hours	☐ 6 - 10 hours
2. Sit	☐ 1 - 3 hours	☐ 3 - 5 hours	☐ 5 - 10 hours	
3. Drive	☐ 1 - 3 hours	☐ 3 - 5 hours	☐ 5 - 10 hours	

B. Patient may use hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
RIGHT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
LEFT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

C. Patient may use feet for repetitive movement as in operating foot controls . . . . . ☐ Yes ☐ No

D. During the day, is the patient able to:

	67 - 100%	34 - 66%	1 - 33%	0%
1. Bend	☐	☐	☐	☐
2. Squat	☐	☐	☐	☐
3. Climb	☐	☐	☐	☐
4. Twist Body	☐	☐	☐	☐
5. Push	☐	☐	☐	☐
6. Pull	☐	☐	☐	☐
7. Balance	☐	☐	☐	☐
8. Kneel	☐	☐	☐	☐
9. Crawl	☐	☐	☐	☐
10. Grasp	☐	☐	☐	☐
11. Reach	☐	☐	☐	☐

E. Maximum lifting is _____ pounds

F. Can the employee work an 8 hr. day with the above restrictions? . . . . . ☐ Yes ☐ No
If not, how many hours could they work with the above restrictions? _____

7. Physical Impairment

☐ Class 1 No limitation of functional capacity;
capable of heavy work* . . . . . No Restrictions (0 - 10%)

☐ Class 2 Medium manual activity* . . . . . (15 - 30%)

☐ Class 3 Slight limitation of functional capacity;
capable of light work* . . . . . (35 - 55%)

☐ Class 4 Moderate limitation of functional capacity;
capable of clerical/administrative (sedentary*) activity . . . . . (60 - 70%)

☐ Class 5 Severe limitation of functional capacity;
incapable of minimum (sedentary*) activity . . . . . (75 - 100%)

* As defined in the U.S. Department of Labor Dictionary of Occupation Titles

8. Cardiac (if applicable)

A. Functional Capacity (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 3 (Marked Limitation)
☐ Class 2 (Slight Limitation) ☐ Class 4 (Complete Limitation)

B. Therapeutic Class (Activity)

☐ No Restriction ☐ Moderate Restriction ☐ Complete Restriction
☐ Slight Restriction ☐ Marked Restriction

C. Blood Pressure - Last Visit _____

9. Mental Impairment (if applicable)

☐ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitation)

☐ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)

☐ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)

☐ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)

☐ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustments (severe limitation)

A. Do you believe this patient is competent to endorse checks and direct the use of proceeds thereof? . . . . . ☐ Yes ☐ No

B. What is the patient's current DSM-IV-R diagnosis?

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

10.Work Capabilities

A. Is patient capable of working within these limitations? . . . . . ☐ Full time ☐ Part time

B. Is patient capable of another occupation on a full-time basis? . . . . . ☐ Yes ☐ No
On a part-time basis? . . . . . ☐ Yes ☐ No

11.Prognosis

A. How long will these limitations apply?

Full-time work?	☐ 3 weeks or less	☐ One Month	☐ 1 - 2 Months
	☐ 2 - 3 Months	☐ 4 - 6 Months	☐ Permanently
Part-time work?	☐ 3 weeks or less	☐ One Month	☐ 1 - 2 Months
	☐ 2 - 3 Months	☐ 4 - 6 Months	☐ Permanently

B. If you expect a fundamental change in limitations, please describe.

12.Vocational Rehabilitation

A. Have you reviewed the material and substantial duties of the patient's occupation? . . . . . ☐ Yes ☐ No

B. Would vocational counseling and/or vocational rehabilitation be recommended? . . . . . ☐ Yes ☐ No

C. Would job modification enable patient to work with impairment? . . . . . ☐ Yes ☐ No
If yes, how?

13.Remarks

14.Information About the Attending Physician

Name of Attending Physician (first, middle initial, last)			Degree/Specialty
Physician's Street Address	City	State	Zip Code
Physician's Email Address	Telephone Number	Fax Number	
Physician's Tax ID Number			

I understand that some states require Sun Life Assurance Company of Canada to notify me that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Attending Physician's Signature* X	Date (m/d/y)

* A stamp or signature of a person other than the examining physician is not acceptable.